Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTHWEST TEXAS HOSPITAL
3255 WEST PIONEER PARKWAY
ARLINGTON TEXAS 76013

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-09-0789-01

MFDR Date Received
September 26, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As of 3/1/08, the outpatient fee schedule is 200% x MAR. Prior to that date, 125% x MAR was considered Fair & Reasonable. Medicare would have allowed this facility $256.60. Multiply this by 125% = $320.75. Based on the insurance payment, a supplemental payment of $64.15 is due. We maintain to give our patient the best of care available but if our bills are constantly reduced to what the carrier's feel is 'fair and reasonable' we will one day face having to close our facility as most of the times this 'fair and reasonable' payments barely cover our cost to operate and maintain the highest level of service that our patients require and deserve, especially regardless of whether or not they are Work Comp. We request additional payment of $64.15... Please note that no PPO deductions were taken on this claim."

Amount in Dispute: $64.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. All reductions of the disputed charges were made appropriately."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 9, 2008 to January 31, 2008	95832, 97022, 97033, 97035	$64.15	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas.
3. Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.
4. 28 Texas Administrative Code §134.401(a)(3), effective August 1, 1997, sets out the Acute Care Inpatient Hospital Fee Guideline.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 4, 2008
   - 120-101 – The allowance for this code has been included in the total allowance for the bill
   - 900 – Based on further review, no additional allowance is warranted
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Did the requestor submit documentation to support fair and reasonable reimbursement?
2. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to outpatient physical therapy services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401(a)(3), effective August 1, 1997, 22 TexReg 6264, which states that "Services such as outpatient physical therapy, radiological studies and laboratory studies are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services."
2. Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division Rule at 28 TAC §133.307(c)(2)(G) , effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable"... Review of the submitted documentation finds that:
   - The requestor's position statement states that "As of 3/1/08, the outpatient fee schedule is 200% x MAR. Prior to that date, 125% x MAR was considered Fair & Reasonable. Medicare would have allowed this facility $256.60. Multiply this by 125% = $320.75. Based on the insurance payment, a supplemental payment of $64.15 is due."
   - The requestor submitted a letter of reconsideration to the insurance carrier on April 9, 2008, the requestor wrote "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the allowable of $256.60. Allowing this at 125% would yield a fair and reasonable allowance of $320.75. Based on your payment of $256.60, a supplement payment is still due of $64.15."
   - The requestor does not discuss or explain how additional payment of $64.15 would result in a fair and reasonable reimbursement.

- The requestor did not discuss or explain how it determined that the 125% of Medicare rate would yield a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The requestor did not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.
- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the proposed methodology.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

5. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		May 14, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.